UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

NUCYNTA (tapentadol)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Must be age 18 or above
- Documented failure or GI intolerance to conventional analgesics.
- No concomitant use of MAOIs.

INFORMATION:

Therapy is authorized for up to ten days of use per acute injury episode.

AUTHORIZATION:

10 days.

RE-AUTHORIZATION:

Same as initial.

1/19/10